USE PATIENT LABEL WHEN AVAILABLE

HEALTH SERVICE NAME

ADULT SEPSIS PATHWAY

Medical Record No:.....

Surname: .....

Forename: .....

Gender: ..... D.O.B. .....

AFFIX PATIENT IDENTIFICATION LABEL HERE

For Illustration Purposes Only

RECOGNISE

Use for patients aged ≥ 16 years. (Maternal sepsis pathway recommended for current pregnancy or within 6 weeks post-pregnancy).
Clinical pathways / guidelines do not replace expert clinical judgement.
Consider Goals of Patient Care when planning clinical care.

If you suspect febrile neutropenia / neutropenic sepsis immediately refer to local guidelines.

SEPSIS is infection with organ dysfunction and is a MEDICAL EMERGENCY.

Could this be sepsis? Tick all signs and symptoms of infection that apply.

- ☐ Fevers / rigors / chills / hypothermia
- ☐ Myalgia / general malaise / non-specific weakness
- ☐ Dysuria / oliguria / urinary frequency
- ☐ Redness / swelling / infected wound / cellulitis / new rash
- ☐ Cough / sputum / breathlessness / sore throat
- ☐ Vomiting / diarrhoea / abdominal pain
- ☐ Headache / photophobia
- ☐ New or acute changes in mental state

High-risk patients

- ☐ Immune compromised
- ☐ Indwelling devices (e.g. intravenous (IV) lines / catheters)
- ☐ Recent surgery / invasive procedure
- ☐ Re-presentation within 48 hours / recent sepsis hospitalisation
- ☐ Pregnant / within 6 weeks of pregnancy
- ☐ Aboriginal or Torres Strait Islander
- ☐ Family / carer/ patient / clinician concern
- ☐ Falls / advanced age ≥ 65 years / frailty
- ☐ IV drug use
- ☐ Diabetes / Renal disease

Commence a systematic assessment of patient and take full set of vital signs

ESCALATE

Suspected Infection PLUS

ANY observation/s that triggers insert site specific escalation OR any of the following:

- ☐ Respiratory rate 21-24
- ☐ Systolic BP 90-100
- ☐ Heart rate 90-129
- ☐ Urine output < 1mL/kg/hour or not passed urine in past 12-18 hours
- ☐ Deterioration since last assessment
- ☐ Lactate ≥ 2 mmol/L

Patient may have SEPSIS

- ☐ Obtain Medical Review (as per local escalation process within 30 mins
  - State "Sepsis review required"
- ☐ Treating clinician to notify patient's medical team

ANY observation/s that triggers insert site specific escalation OR any of the following:

- ☐ Respiratory rate ≥ 25 or new O_2 requirements
- ☐ Systolic BP <90 (or > 40mmHg below usual)
- ☐ Heart rate ≥ 130
- ☐ Urine output < 0.5mL/kg/hour or not passed urine in past 18 hours
- ☐ Mottled / ashen / cyanotic or non-blanching rash
- ☐ Evidence of altered mental state
- ☐ Lactate ≥ 4 mmol/L

Patient has SEPSIS OR SEPTIC SHOCK until proven otherwise

- ☐ Activate a **MET Call** if patient meets **MET** criteria.

If patient does **not** meet **MET** criteria:

- ☐ Obtain **Medical Review (as per local escalation process)** within 15 mins
  - State "Sepsis review required"

If no response within 15 mins:

- ☐ Escalate immediately to **Senior Medical Officer**.

Outcome of Medical Review – complete relevant response.

☐ **Unlikely Sepsis**

Consider other differential diagnosis.
Re-evaluate and escalate as indicated.

☐ **SUSPECTED SEPSIS WITH OR WITHOUT SHOCK**

Commence resuscitation and sepsis management as per page 2

Date: _____ Time of review: _____

Name: _____ Signature: _____ Designation: _____

DO NOT WRITE IN BINDING MARGIN

HCHPCXXXXXX

MXXX
09/26

MRXXX ADULT SEPSIS PATHWAY

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COMPLETE ACTIONS 1-4 WITHIN ONE HOUR

RESUSCITATE

1. Senior Medical Review
- Oxygen if required: aim SpO2 ≥ 95% (88-92% for patients at risk of hypercapnia)
- Consider infection source

☐ Full set of observations and urine output

5 min

2. Vascular access and investigations
- **Do not delay antimicrobials or fluids if pathology collection is difficult**
- Obtain prompt IV or Intraosseous access
- Collect 2 sets of blood cultures (single site collection preferred) Add an additional (third) set via any central line in situ
- Collect microbiological samples based on possible infection source
- Consider relevant imaging to identify infection source

☐ Lactate. Result: _____
☐ Blood cultures x 2 sets
☐ FBC, UEC, LFTs, BGL, CRP
☐ Add coagulation screen for septic shock
☐ Other cultures / investigations

30 min

3. Commence Antibiotics
- Prescribe according to local guidelines or Australian Therapeutic Guidelines
- Consider allergy status. Consider any microbiology results
- Consider consult with ID physician or microbiologist if multidrug resistant or unusual organism suspected

☐ Antimicrobial administered

Time: _____

60 min

Antibiotic guidance QR code

Local guideline / Australian Therapeutic Guidelines

4. Fluid resuscitation for septic shock / hypoperfusion

IV fluid challenge
- Isotonic crystalloid bolus 500-1000mL
- Assess perfusion response post bolus: Capillary Refill Time, conscious state, respirations, pulse, BP
- Seek early expert advice on fluid volume & vasopressor management for renal / heart failure / cardiology patients

Haemodynamic support
- Repeat IV bolus(es) of 250-500mL based on perfusion assessment/s (max 30mL/kg)
- Seek expert help (eg: critical care)
- Commence vasopressor infusion as per local guidelines if inadequate perfusion persists despite fluid resuscitation
- Initial Mean Arterial Pressure (MAP) target ≥ 65mmHg
- Monitor fluid balance and consider urinary catheter

☐ IV Fluid bolus given
☐ IV Fluid not indicated
☐ Vasopressors commenced if required

REASSESS & REFER

5. Reassess
- **Source control is URGENT:** Consider infection source e.g. line / catheter / surgical / wound
- Review fluid balance / haemodynamic status / observations

☐ Repeat lactate (within 2 hours)
☐ Sepsis diagnosis and management plan documented
☐ Plan discussed with family / carers

6. Refer
- Consider critical care, retrieval, or surgical services
- Comprehensive clinical handover (iSoBAR)

☐ Referral arranged
☐ Intra / inter hospital transfer arranged

Monitor closely for deterioration and **escalate as per local process.**
Actively seek microbiology and investigation results and **review antimicrobial regimen within 24-48hrs.**

Resources:

Site sepsis guideline QR code

Local sepsis guideline

Consumer resources QR code

Consumer resources:
For patient or family / carer as appropriate