Sepsis: recognition, diagnosis and early management guidelines

This document provides guidance for nurses to identify and initiate treatment for patients with suspected or confirmed sepsis at a Southern Cross Hospital.

These guidelines are supported by the Best Practice Advocacy Centre New Zealand (bpacnz) 2018 Sepsis guidelines. They have been designed to support timely care however does not replace clinical judgement.

Read the full detailed BPACNZ guidelines here - Sepsis: recognition, diagnosis and early management.

The Sepsis-3 definition devised in 2019 defines sepsis as:

Sepsis is life-threatening organ dysfunction due to a dysregulated host response to infection. Patients at risk of sepsis can be identified if they have two or more of the following:

- **H**ypotension: SBP less than or equal to 100 mmHg
- **A**ltered mental status (any GCS less than 15)
- **T**achypnoea: RR greater than or equal to 22

Patients and whānau always have the right to be involved in discussions and make informed decisions about their care and kept up to date. Guidelines for Kōrero Mai: Patient and whānau escalation of care process

Sepsis can be difficult to detect in its early stages, but if the signs and symptoms are recognised early, it could save a life. Consider that people with sepsis may have non-specific, non-localised presentations - for example, feeling very unwell - and may not have a high temperature.

Patients with a confirmed or suspected infection and significant risk factors have a high risk of poor outcomes. Clinical teams should respond with urgency.

Procedure

For a patient with EWS 3 or above and/or looks sick - always ask yourself: 'Could this be sepsis?' and complete the relevant sepsis screening and action tool below:

- Adult Sepsis Screening and Action Tool (>15years)
- Paediatric Sepsis Screening and Action Tool (<15 years). Presentation of sepsis in children can be atypical as they have excellent compensatory mechanisms.

- All patients with suspected sepsis, nursing observations must be increased to a minimum of hourly or aligned with the NZEWS escalation process
- Medical specialist review timeframes must align with the NZEWS or Sepsis screening tool algorithm
- Pay close attention to the patient or whānau if they are concerned. Discuss possibility of escalation of care with whānau
- Consider patients who may be at higher risk by using the risk stratification tool here (children under 5, children 5-11, > 12)
- Alert CNS, senior nurse on-call for further support and guidance
- Consider transfer to an available high observation area e.g. high dependency

- Lactate measurement is done if measuring devices are available, or urgent bloods and blood cultures are sent to the laboratory
- Blood cultures are taken before antibiotics administered. Blood culture collection procedure
- Sepsis antibiotic empiric guidelines can be found here.
- Carry out a thorough clinical examination to look for sources of infection as part of the initial assessment. Tailor investigations of sources of infection to the patients clinical history and findings on examination
- Consider urine analysis and chest x-ray in all patients with suspected sepsis
- Consider further imaging (abdo/pelvis) if nothing identified from initial tests
- Consider other possible sources infection – sputum, wound, faecal, drain output, IV site - obtain relevant samples
- For patients remaining and being treated in a SCH facility, follow the models of care for high dependency care and the adult monitoring guideline
- Follow the NZEWS escalation pathway or sepsis screening tool and arrange transfer as required following the 'Transfer of patients to another healthcare facility' guideline
- Any delays in transfer may require consideration of the Sepsis Hypoperfusion Pathway (Sepsis Trust NZ, PDF)

All nurses working in clinical care are expected to complete the sepsis education module to support early recognition and assessment and to ensure they have the skills and knowledge to commence initial treatment and escalation as required. The National vital signs and early warning scoring chart learning package should be completed as a prerequisite to this.

Thanks to the NZ Sepsis Trust for their support and for sharing their clinical tools.

Associated Documents

- Prehospital adult sepsis screening and action tool
- Prehospital paediatric sepsis screening and action tool
- Standing order template - sepsis six - oxygen
- Standing order template - sepsis six - IV fluids
- Prevention of central line acquired bloodstream infection (CLABSI)
- Sepsis audit tool

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